Government of the District of Columbia
Department of Human Services
Income Maintenance Administration

MEDICAL EXAMINATION REPORT

Customer/Patient Name: _____ Date of Birth ___/___/___

Address: _____ Phone Number: _____

Gender: _____ Race: _____ Case Number: _____

IMA Worker Name: _____ Phone Number: _____ Section: _____

Reason for Referral: _____

_____

_____

_____

Physical Examination Report ***(To be completed by medical professional)*****:**

Name of Medical Provider: _____ Phone Number: _____

Date of Examination: ___/___/___

Diagnosis: _____

_____

_____

_____

Treatment ***(past and current)*****:** _____

_____

_____

_____

_____

Objective Findings ***(Give report of X-rays, EKG's, laboratory, or other diagnostic tests, with dates. Use separate sheet if necessary)*****:** _____

_____

_____

_____

_____

_____

_____

_____

Evaluation:

Characteristics of Major Disability (check one): □ Permanent □ Temporary □ Stable
□ Slowly Progressive □ Rapidly Progressive □ Improving

Can the major disability be moved by treatment? □ Yes □ No
If yes, anticipated duration: _____

Can the major disability be substantially improved by treatment? □ Yes □ No
If yes, anticipated duration: _____

Physical Capacities ***(Use the following symbols: √=No Limitations; X=Limitation; 0=to be avoided):***

Physical Activities:

___ Walking ___ Standing ___ Stooping ___ Kneeling ___ Lifting

___ Reaching ___ Pushing ___ Pulling ___ Other(specify): _____

Working Conditions:

___ Outside ___ Inside ___ Humid ___ Dry ___ Dusty

___ Sudden temperature changes ___ Other (specify): _____

Recommendations:

□ Hospitalization (specify reason and duration): _____

□ Treatment (specify reason and duration): _____

□ Special Facility (specify personal care, nursing, constant protective supervision, etc.):_____
_____

Remarks ***(Please provide additional information clarifying the customer's condition)*****:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I hereby give consent for this information to be used with permission of the applicant, by the Department of Human Services as needed in connection with its rehabilitative services to the applicant.

_____ _____ _____
Signature of medical professional Printed name of medical professional Telephone

_____ _____
Date Address

(rev. 04/03)